**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PRIDE
5701 MAPLE AVENUE SUITE 100
DALLAS TX 75235

**Respondent Name**
ACE AMERICAN INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 15

**MFDR Tracking Number**
M4-12-2387-01

**MFDR Date Received**
MARCH 10, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per the explanation of benefits from Sedgewick/SRS the claims are being denied for timely filing which is not valid because the claims were billed in a timely manner. This claims were processed by ESIS originslly them SRS took over and then Sedgwick murged with them or whatever so we shoul dnot be penalized for there chnges becase we were not notified this was going to happen until after it was done so how would we know to send the claims elsewhere." [sic]

**Amount in Dispute:** $5,250.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Carrier issued reimbursement in the amount of $875.00 per applicable fee guidelines for service date 3/23/2011."

**Response Submitted by:** Indemnity c/o Flahive, Ogden & Latson, P.O. Box 201320, Austin, TX 78720

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 14, 2011 through March 15, 2011 | Chronic Pain Management Program CPT Code 97799-CP-CA (15 hours) | $1875.00 | $1,875.00 |
| March 21, 2011 through March 23, 2011 | Chronic Pain Management Program CPT Code 97799-CP-CA (14 hours) | $1750.00 | $875.00 |
| March 30, 2011 through April 1, 2011 | Chronic Pain Management Program CPT Code 97799-CP-CA (13 hours) | $1625.00 | $1,625.00 |
| TOTAL | | $5,250.00 | $4,375.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code, Section §408.027(a), titled *PAYMENT OF HEALTH CARE PROVIDER*, effective September 1, 2007, states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
3. Texas Labor Code, Section 408.0272(b), titled *CERTAIN EXCEPTIONS FOR UNTIMELY SUBMISSION OF CLAIM,* effective September 1, 2005, states "(b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."
4. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, sets out reimbursement guideline for specific medical professional services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 11, 2011, and July 12, 2011
   - 29-The time limit for filing has expired.

   Explanation of benefits dated August 3, 2011
   - This procedure on this date was previously reviewed.
   - 18-Duplicate claim/service.
   - 29-The time limit for filing has expired.

   Explanation of benefits dated September 29, 2011
   - Reimbursement based on usual, customary and reasonable for this geographic region.
   - 217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - 29-The time limit for filing has expired.
   - W1-Workers compensation state fee schedule adjustment.

**Issues**

1. Did the requestor support position that disputed claims were submitted timely?
2. Is the requestor entitled to reimbursement?

**Findings**

1. According to the submitted explanation of benefits, the respondent denied reimbursement for the chronic pain management program based upon reason code "29-The time limit for filing has expired".

   The requestor states on the September 22, 2011 Fax Cover Sheet that "These claims were originally processed by ESIS and from what we were told today the claim are to be processed by your office and the entire file has been moved to Sedgwick. So if you can disregard the timely filing on these claims that would be appreciated."

   In support, the requestor submitted copies of fax status activity reports that indicate that the disputed bills were submitted to Specialty Risk Services on: dates of service March 14, 2011 through March 15, 2011 on May 4, 2011; dates of service March 21, 2011 through March 23, 2011 on May 24, 2011; and dates of service March 30, 2011 through April 1, 2011 on April 14, 2011.

   The respondent states in the position summary that the disputed services were not submitted timely, however, payment of $875.00 was issued for date of service March 23, 2011 that was received by the insurance carrier on the same date, July 7, 2011, as the other disputed dates. The respondent's position is not supported.

   The requestor submitted proof satisfactory to the division that the provider within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title in accordance with Texas Labor

Code, Section 408.0272(b)(1)(C). Therefore, the disputed services were submitted timely.

2. 28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP-CA for forty two (42) hours on the disputed dates of service Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x forty two hours $5,250.00. The carrier paid $875.00 for date of service March 23, 2011. Therefore, the difference between the MAR and amount paid is $4,375.00. This amount is recommended for reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,375.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,375.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 9/28/2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.